



TO: Interested Parties

FROM: Denine Northrup, Ph.D., Director of Quality Management and Improvement, DMHAS

DATE: 8/6/03

RE: **Lessons Learned Initiative**

As we work together to improve the quality of publicly supported behavioral health services in an environment of scarce resources, it is important that we incorporate lessons learned from the many exemplary and innovative programs funded (and in some cases operated) by DMHAS. Knowledge gained from these successes can inform the Department's planning in ways that promote development of a recovery-oriented system of care.

As a part of the planning process, Commissioner Thomas Kirk and Deputy Commissioner Arthur Evans have asked that we create an inventory of "Lessons Learned" from such programs and initiatives for use in guiding policy and programmatic decisions. We believe that the direct experiences of consumers/people in recovery and providers in the field must inform this initiative, so we are requesting your assistance in compiling this summary

The intent of this survey, and the Lessons Learned project as a whole, is to ensure that we offer the highest quality of care possible even during difficult fiscal times. This survey will provide valuable input to the Department's strategic planning process and will allow DMHAS to move forward despite current challenges.

We are seeking the kinds of lessons that have the potential to influence important aspects of care delivery, particularly lessons supported by data. The lessons learned may address care delivery from many perspectives – from practice methods, to program design, to policy development, to management processes. We are particularly interested in lessons that prevent the onset of behavioral health disorders, improve access, retention, or treatment outcomes, or promote long-term recovery.

Please complete the attached table following the instructions provided. Please be brief in your responses and focus on a few (two, three, or four?) of the lessons that you believe to be the most important. Please e-mail your responses to Janis Tondora (janis.tondora@yale.edu) by Friday, August 22nd. Responses may also be mailed to Janis Tondora at the Yale Program for Recovery and Community Health, 319 Peck Street, Building 6, Suite 1C, New Haven, CT 06513. Feel free to get input from representatives within your agencies, and if you have questions, please contact either Janis at (860) 418-6754 or Denine Northrup (860) 418-6738. Thank you for your help in this important endeavor.

Lessons Learned Survey - Instructions & Examples

I. BRIEF DESCRIPTION OF LESSON LEARNED & MAJOR IMPLICATIONS: Lessons may focus on successes, failures, implementation barriers, innovations, or creative solutions to common problems. Please comment on the generalizability or adaptability of the lessons to other agencies, settings, populations, etc. Also, please describe significant implications of the lesson for one or more of the following areas: Clinical Practice, Program Design, Policy Development, and Management Processes.

II. SERVICE PROGRAMS THAT EXEMPLIFY THE LESSON: Please identify a program/intervention that demonstrates this lesson. Include relevant information such as the specific need(s) that led to the development of this program; discuss program goals, target populations, and desired outcomes; and clearly describe any innovative aspects of the program.

III. DATA THAT SUPPORT THE LESSON(S): Please tell us about the type of data that informs the lesson and include the basic methods through which the data was obtained, e.g., pre-post testing, satisfaction surveys, administrative databases, first-hand experience, etc.

IV. CATEGORIZE YOUR DATA: Please refer to the criteria listed in the attached document entitled “*Levels/Types of Evidence Defined*” and categorize your data into one of the four groups shown.

<u>EXAMPLES</u>				
I. Brief Description of Lesson Learned & Major Implications	II. Example Program Demonstrating Lesson	III. Data that supports the lesson	IV. How would you categorize this evidence? Please check one.	
<i>The Individual Placement and Support (IPS) model of supported employment is an effective vocational rehabilitation approach that supports recovery. Supported employment programs using this approach should strive for maximum fidelity to the IPS model, including an emphasis on the integration of clinical and rehabilitation services.</i>	<i>Former IPS program at CRMHC instituted to examine the use of supported employment to increase low employment rates among individuals with serious behavioral health disorders. IPS emphasizes rapid-placement, consumer preferences, and integration of clinical and rehab services.</i>	<i>The rate of competitive employment using the IPS model was 75%, in contrast to more traditional models that achieved placement rates of 27.5% and 17.9% respectively. The total mean hours consumers worked in competitive positions were also significantly higher in the IPS programs with an average of 338.27 hours vs. 102.84% and 39.96%. Pilot used a randomized controlled trial to achieve these findings.</i>	Evidence Based	X
			Evidence Supported	
			Evidence Informed	
			Evidence Suggested	
<i>The use of utilization management strategies to match service recipient needs with levels of care is both clinically appropriate and cost effective. UM strategies help ensure that people who have been unsuccessful at moving from acute care services through the continuum of care can be offered alternatives that improve outcomes.</i>	<i>Opioid Agonist Treatment Protocol: OATP provides rapid induction to opioid therapy and priority access to methadone providers. The protocol identifies frequent users of acute care services and then offers them a variety of additional supports such as ICM and Recovery Houses.</i>	<i>62% of OATP participants connected to less intensive/costly level of care following discharge from detox as opposed to 32% of patients who were eligible but chose not to participate. The protocol is not randomized or controlled but the data shows positive outcomes over time.</i>	Evidence Based	
			Evidence Supported	X
			Evidence Informed	
			Evidence Suggested	

DMHAS STAKEHOLDER SURVEY

Your Name: _____ **Phone #:** _____ **Date:** _____

DMHAS Stakeholder Role: Provider ____ Consumer/Person in Recovery ____ Other Stakeholder, Please note: _____

I. Brief Description of Lesson Learned & Major Implications	II. Example Program Demonstrating Lesson	III. Data that supports the lesson	IV. How would you categorize this evidence? Please check one.	
INSERT YOUR LESSONS HERE AND USE ADDITIONAL ROWS AS NECESSARY.			Evidence Based	
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Levels/Types of Evidence Defined

Purpose: DMHAS, like other state behavioral health agencies, is working to implement Evidence-based Practices (EBPs) wherever possible. However, scientific research is often incomplete and inadequate in many important areas of clinical practice. Additionally, it takes an astounding average of 17 years for new knowledge generated by randomized controlled trials to be incorporated into clinical practice.¹ This unacceptably long *science-to-service* waiting period has forced behavioral health policymakers to consider using other forms of “evidence” to guide programmatic and resource allocation decisions.

DMHAS is using the following four categories to evaluate levels/types of evidence used to support clinical interventions, program design and systems policy changes.

Evidence Based

- Interventions, which have a body of, controlled studies and where at least one meta-analysis shows strong support for the practice.
- Results have a high level of confidence, due to randomized control factor

Example: A series of randomized controlled trials comparing supported employment (also referred to as “IPS, Individual Placement and Support”) with a variety of traditional, “step-wise” vocational programs has clearly established supported employment as a highly effective intervention. This intervention results in significant gains in competitive employment rates, earned income levels, and employment tenure among individuals with severe behavioral health disorders.

Evidence Supported

- Interventions that have demonstrated effectiveness through quasi-experimental studies (e.g., “Time Series” studies or detailed program evaluations that include data on the impact of the programs or interventions).
- Data from administrative databases or quality improvement programs that shed light on the impact of the program or intervention.

Example: As one component of a quality improvement program in a local mental health authority, an in-service training program for providers and consumers/people in recovery was offered regarding the use of strategies to improve the collaborative, person-centered nature of treatment planning. Pre-post data collected prior to and after the training intervention indicated significant improvements in consumer satisfaction and consumers’ level of participation in treatment planning.

¹ From a 2001 report published by the Institute of Medicine (IOM), an arm of the National Academy of Sciences, entitled – *Crossing the Quality Chasm: A New Health System for the 21st Century*

Evidence Informed

- Evidence of the effectiveness of an intervention is inferred based on a limited amount of supporting data.
- Based on data derived from the replication of an EBP that has been modified or adapted to meet the needs of a specific population.
- This data is fed back into the system. New interventions are developed, traditional interventions are modified, and ineffective interventions are eliminated.
- Provides a template/framework for other systems to modify their programs and interventions.

Example: MET has been shown to be a highly effective approach for engaging people into treatment. While no studies have examined the use of MET specifically with African American men, based on the overall effectiveness of MET, it is reasonable to extrapolate and pilot this approach within this population. Data from the pilot will determine if extrapolation was an appropriate decision and identify potential MET modifications necessary for the specific population of African American men.

Evidence Suggested

- Consensus driven, or based on agreement among experts.
- Based on values or a philosophical framework derived from experience, but may not yet have a strong basis of support in research meeting standards for scientific rigor.
- Provides a context for understanding the process by which outcomes occur.
- Based on qualitative data, e.g., ethnographic observations.

Example: Experience has shown us the importance of Culturally Competent and Recovery-Oriented Care, yet scientific evidence lags behind the expert and values-based and anecdotal consensus regarding the effectiveness of these approaches.